will carefully review the case and document the rationale for the decision; i.e., fully state the evidence and the reasons that were the basis for approval of denial. The review must be dated and include the clinical specialty of the reviewer (e.g., M.D., D.O.) and signature and legibly printed name of the reviewer. The physician reviewer must document his or her rationale for the approval or denial of coverage in a brief written opinion in the case file. The opinion must be signed (not initialed) by the reviewer. To expedite out-of-system claims processing and to make more effective use of physician medical advisors, telephone consultations with the advisor may be used if the following provisions are met:

**(1)** The consultation must be handled by a supervisory level registered nurse medical reviewer or by a physician member of the FI/Contractor's advisory staff.

**(2)** There must be great care taken to prevent misunderstanding of the circumstances of the case and the medical advisor's recommendations.

**(3)** The matters discussed and the recommendation must be thoroughly documented, including the date, the rationale for the decision/recommendation, the name of the caller and the name of the medical advisor.

**(4)** The medical advisor who was contacted must review the actual case file and countersign the written decision within ten (10) workdays of the call. The case should not be delayed for the signature.

**(5)** The use of telephone calls must not be used to replace in-person medical advisor reviews, but to supplement them and to increase the ability to speed processing and to increase involvement of appropriate specialists in effective review of complex cases.

## 5. Abortion Services

### a. TRICARE/CHAMPUS Claims Review and Processing Procedures

#### (1) *Processing*

*MCS* contractors shall process all claims for abortion services/supplies (including claims for consultation services) in accordance with the TRICARE/CHAMPUS Policy Manual, Chapter 3, Section 13.6. Automated prepayment edits are required for induced abortion procedures.

#### (2) Denial of Payment

*When a service(s) is denied due to an abortion, a letter of explanation shall be sent, but only when the denial is questioned by the beneficiary.* Figure 2-1-A-12 provides suggested wording for abortion claims that are denied. **The explanation shall be provided only to the beneficiary and participating provider**. The special denial letter shall be sent in an envelope marked "personal". **It is EMPHASIZED that using a *TRICARE*/CHAMPUS Explanation of Benefits is NOT acceptable for denial of abortion services**. Only an approved letter may be used.

### b. Request for Reconsideration

Refer to *the* OPM Part Two, Chapter 6, **Appeals and Hearings**, for processing reconsiderations.

### c. Processed Claim Records: Abortion Services and Supplies

The *MCS* contractor shall be able to retrieve the hard copy of all processed claims for abortion services and supplies, whether paid or denied, upon request by *TSO*. Such recovery must be completed within *fifteen (15)* workdays of receipt of such request.

## 6. Liver Transplant Claims

Benefits are payable for liver transplantation when the service meets the requirements specified in the TRICARE/CHAMPUS Policy Manual, Chapter 3, Section 8.5. (Provider and reimbursement requirements are also included in the Policy Manual.)

## 7. Heart Transplant Claims

Benefits are payable for heart transplantation when the service meets the requirements specified in the TRICARE/CHAMPUS Policy Manual, Chapter 3, Section 5.3. (Provider and reimbursement requirements are also included in the Policy Manual.)

## 8. Birthing Centers Claims

Refer to the TRICARE/CHAMPUS Policy Manual, Chapter 1, Section 7.1, (related emergency services) and Chapter 6, Section 6.1 (hospital-based birthing rooms); Chapter 10, Section 1.3, (birthing centers); Chapter 10, Section 1.3 (professional services and cost-share); and Chapter 11, Section 11.2 (provider certification process).

## 9. Hospice Claims

Benefits are payable for hospice care when the services meet the requirements specified in the TRICARE/CHAMPUS Policy Manual, Chapter 13, Section 22.1D. (Provider and reimbursement requirements are included in this section.)

# K. CHAMPVA Claims

## 1. Background

**a.** Effective December 1, 1990, the CHAMPVA Center of the Department of Veterans Affairs, hereafter referred to as the "CVAC," began processing claims for CHAMPVA beneficiaries residing in the state of New Hampshire. This limited responsibility for claims processing will assist the CVAC in refining program procedures before it begins processing claims on a regional basis effective July 1, 1991.

**b.** Effective July 1, 1991, the CVAC will process claims for CHAMPVA beneficiaries residing in the Mid-Atlantic Region and will phase-in claims processing for CHAMPVA beneficiaries residing in the other TRICARE/CHAMPUS regions at approximately two-month intervals, thereafter.

children as well as different types of former spouses. Sample relationship downloading logic appears in *the* ADP Manual, Chapter 9, Section IV.C.7.

### f. Patient's Identification Card Information

*TRICARE* claims require ID card information only if the patient is not on DEERS and the claim is payable under the guidelines in the ADP Manual, Chapter 9.

### g. Sponsor's Full Name

The sponsor's last name and first name must be present on each claim. Develop if the sponsor's name is incomplete, discrepant, or missing or an initial or nickname is used.

***NOTE:***

*For purposes of TRICARE claims submitted by eligible former spouses, "Sponsor" is to be the member or former member.)*

### h. Sponsor's Social Security Number

The sponsor's Social Security Number must be present on each claim (except NATO members and dependents of active duty Security Agents). The SSN which appears on DEERS shall be used for claims processing, history, CEOB and HCSR reporting purposes, unless it can be proven to be erroneous. Do not override DEERS in the absence of clear and convincing evidence (such as copies of social security cards, orders, ID cards, etc.) that the information which appears on DEERS is incorrect. The sponsor's service number is acceptable in those cases in which a social security number was never obtained/ issued. If a participating provider's claim is received with no SSN, the *MCS* contractor shall telephone the provider for the SSN. If a nonparticipating claim lacking the SSN contains the beneficiary's telephone number, the *MCS* contractor shall call the beneficiary to obtain the SSN. If the SSN is not obtainable by telephonic development or from history, the *MCS* contractor is to return the claim uncontrolled with an explanation of the reason it is being returned, e.g., the sponsor's SSN must be provided in order to process a claim. If a sponsor is a NATO member, NATO shall be entered on the claim along with a copy of the *family member's* ID card. If the sponsor is an active duty Security Agent, and is restricted from furnishing his/her SSN, "Security" should be entered on the claim and dependents must attach a copy of their ID card with the claim. Control develop if this information is incomplete, discrepant, or missing, *i.e., for NATO electronic media claims (EMC) the copy of the dependent's ID card will not be attached to the claim; therefore, controlled development for the copy of the ID card shall be conducted.* For DEERS SSN downloading requirements, refer to *the* ADP Manual, Chapter 9, Section IV.A.2.b.

### i. Sponsor's Grade or Rank

The sponsor's grade or rank is available on DEERS and shall be used to determine the appropriate deductible category for beneficiaries of active duty sponsors, unless there is other evidence indicating that an active duty sponsor's pay grade is different. If a higher pay grade is reported on the claim than appears on DEERS, and has an impact on deductible or cost share, the DEERS value shall be overridden and the higher value used for purposes of claims processing, history and HCSR reporting. If a lower pay grade is reported on the claim than appears on DEERS, and the lower pay grade would make a difference for purposes of applicable deductible, the *MCS* contractor shall develop for evidence of the actual pay grade. Otherwise, the pay grade reported on the claim shall be

used for purposes of claims processing, history and HCSR reporting. The FI/Contractor is provided override authority in the ADP Manual, Chapter 9, Section II.D.9. If the pay grade category used by the FI/Contractor is questioned by the beneficiary/sponsor, it is the sponsor/beneficiary's responsibility to prove (ID Card or Service documentation; promotion/demotion papers) that the pay grade/rank is incorrect. For DEERS pay grade downloading requirements, refer to ADP Manual, Chapter 9, Section IV.C.3.

***NOTE:***

*The deductible increase does not apply to CHAMPVA beneficiaries. The increase does apply to NATO beneficiaries. See Section I.A.5., NOTE 2 for the Desert Shield exemption.*

### j. Sponsor's Branch of Service

The sponsor's branch of service must be present for each claim. The branch of service which appears on DEERS shall be used for claims processing, history, and HCSR reporting purposes, unless it can be proven to be erroneous. If the branch of service is missing and DEERS does not reflect a value which can be used for claims processing, history, and HCSR reporting purposes, development is required. Do not override DEERS in the absence of clear and convincing evidence (such as copies of orders, ID cards, etc.) that the information which appears on DEERS is incorrect. For DEERS branch of service downloading requirements, refer to ADP Manual, Chapter 9, Section IV.A.2.e.(3)

### k. Sponsor's Status

The sponsor's status (active duty, retired, deceased) at the time the service was rendered must be present on each claim. The sponsor status which appears on DEERS shall be used for claims processing, history, and HCSR reporting purposes, unless it can be proven to be erroneous. Do not override DEERS in the absence of clear and convincing evidence (such as copies of retirement orders, ID cards, etc.) that the information which appears on DEERS is incorrect. For DEERS sponsor status downloading requirements, refer to ADP Manual, Chapter 9, Section IV.C.3.

## 2. Double Coverage Information

A determination regarding other health insurance coverage must be made on all claims. Refer to OPM Part Two, Chapter 3, **Double Coverage**, for information.

## 3. Work-Related/Military Service-Related/Accident-Related Conditions

If the claim form contains indication that one of the these relationships exists, development is required.

### a. Work-Related

When information on the claim form indicates the possibility of liability under Worker's Compensation, the FI/Contractor shall develop information to determine CHAMPUS coverage or referral to Worker's Compensation.

### b. Military Service-Related

A claim in this category could be received from a retiree. If the claim indicates, in any way, that the Veterans Administration has made payment, or has authorized payment, deny the claim.

### c. Accident-Related

Refer to OPM Part Two, Chapter 5, for instructions on developing third party liability claims.

## 4. Signature of Beneficiary

See Section IV.F., for signature requirements.

### a. Unsigned Claim

If a claim is received unsigned, the FI/CRI Contractor may telephonically develop to confirm the beneficiary's signature is on file with the provider. This development must be documented showing the date called, source called (provider office), and information received. If this method is not successful, return the claim to the submitting party for signature. Before returning the claim, it must be carefully screened to ensure all other needed, but missing information is also requested at the same time. An unsigned form need not be retained under system control, whether in-system or out-of-system. Include a notice explaining the signature requirements and the time limits for refiling the claim. (See Section V.D.1., for administrative tolerance for beneficiary signature.)

### b. Signature of Other Than Beneficiary (18 Years of Age or Over)

If a claim is returned to the beneficiary for additional information or release of medical information, develop for the beneficiary's signature, unless the claim indicates the signature is maintained on file by the provider.

### c. Signature of Beneficiary Under 18 Years of Age

#### (1) Nonparticipating Provider Claims

As required, return the claim for the signature of the parent or legal guardian if signed by a beneficiary under 18 years of age, and:

**(a)** He or she is not (or was not) a spouse of an active duty service member or retiree; or

**(b)** The services are not related to venereal disease, drug or alcohol abuse, or abortion.

#### (2) Participating Provider Claims

If a claim is signed by a beneficiary who is under 18 years of age but the provider agrees to participate, it would not normally be necessary to develop for the signature of the parent/legal guardian.

### d. Claims for Certain Ancillary Services - Administrative Tolerance

**(1)** Claims for inpatient anesthesia, laboratory and other diagnostic services in the amount of $50 or less, provided by physician specialists in anesthesiology, radiology, pathology, neurology and cardiology should not be developed or returned for beneficiary signature unless required by state law or FI/Contractor corporate policy.

**(2)** Claims submitted by an institution when the claim is for those specific ancillary services cited in above, should be included in this tolerance if the services were performed in an institution other than the institution in which the beneficiary is receiving inpatient care.

### e. Form HCFA 1500

Item 13, which authorizes payment to provider, does not apply to CHAMPUS claims. Do not develop.

## 5. Provider Information

### a. General

The required information on the various claim forms differs. In general, the name and address of the provider of care, and in some cases, of the referring physician or attending physician, are required. If this information is incomplete, discrepant, or missing on the claim form or on the attached itemized bills, develop as required. (Development for the referring physician for consultation services is not necessary. Reimbursement is to be limited as stated in the Policy Manual, Chapter 1, Section 8.1. The consultation procedure code is to be reported regardless of the application of this limit. The following CEOB message is to be reported for consultations based on the limited amount: "Consultation paid as limited office visit. Referring physician not identified.") The provider's social security number or employer identification number should be present on the claim form. If incomplete, discrepant or missing, obtain from existing file data. (See OPM Part Two, Chapter 2, for Provider Eligibility and the ADP Manual, Chapter 2 for Data File Requirements and Section IV.E., of this chapter for provider identification requirements.)

### b. Agreement to Participate

**(1)** A provider agrees to participate if the participating block is checked "yes" and he/she signs the form. If a provider representative of an institution that is Medicare participating, or subject to the RTC per diem payment system or the mental health per diem payment system, has properly signed UB-92, but the Form Locator 53 has not been checked, the FI/Contractor can still process the claim as participating and need not develop it. Otherwise, if intent to participate is questionable and the out-of-system provider is known to routinely participate, the FI/Contractor shall contact the provider to determine intent. In-system providers must participate under terms of their agreement with the Contractor. When CHAMPUS is the secondary payer, the provider submits the claim and the claim form gives no indication that there was an intent to bill CHAMPUS, then Contractors/FIs shall not assume that the provider intended to participate. On these claims the primary payor should be indicated on the claim; and the provider will agree to participate with the primary payor but will not indicate an intention to participate with

CHAMPUS as a secondary payer. For CHAMPUS to make secondary payments as participating to provider-submitted claims, the HCFA 1500, block 1 "CHAMPUS" should be checked and the provider should agree to participate; or for the UB-92 (outpatient and non-institutional), Form Locator (FL) 50B or 50C should indicate "CHAMPUS" and FL 53B or 53C should have a "Y" (yes).

**(2)** If the provider has agreed to participate, payment to the full extent of program liability will be paid directly to the provider, but the payment to the provider from program and beneficiary sources must not exceed the FI/Contractor determined allowable charge except as provided in payments which include other health insurance which is primary. In such a case, the provisions of the Regulation, Chapter 8; OPM Part Two, Chapter 3; and the Policy Manual, Chapter 13, Section 12.1 will apply.

**(a)** For example, (using the deductible effective April 1, 1991): A participating provider's bill totaled $1,200.00. The beneficiary of an active duty sponsor, anticipating the entire amount as "allowable," paid $150.00 on the deductible and $210.00 for his 20% costshare. The FI/Contractor determined that $1,000.00 was allowable. Since the beneficiary had paid $360.00 toward the bill, $640.00 can be paid to the provider. The calculation and FI/Contractor action will be:

| | |
|---|---|
| $1,200.00 | Billed |
| $1,000.00 | Allowed |
| $-150.00 | Deductible |
| $850.00 | |
| x.80 | |
| $680.00 | Government Liability |
| $-640.00 | Balance Due Provider |
| $40.00 | Paid to Beneficiary |

**(b)** In all cases in which the FI/Contractor has documented knowledge of payment by the beneficiary or other party, the payment shall be appropriately disbursed, including, when necessary, splitting payment. (See OPM Part Two, Chapter 3 for cases where double coverage is also involved.) If it comes to the FI/Contractor's attention that the terms have been violated, the issue shall be resolved as outlined in OPM Part Two, Chapter 7, under procedures for handling violation of participation agreements. If the provider returns an adjustment check to the FI/Contractor indicating that payment had been made in full, an adjustment check may be reissued to the beneficiary/sponsor.

**(3)** If the out-of-system provider is clearly not participating or the intent cannot be determined, pay the beneficiary (parent/legal guardian).

### c. Signature of Provider

**(1)** The signature of the out-of-system provider, or an acceptable facsimile, is required on all participating claims. If an out-of-system participating claim does not contain an acceptable signature, return the claim uncontrolled, with a notice to the provider explaining the signature requirements and the time limits for filing the claim. Also, include a listing of required claim information and request the provider to review the claim once again to ensure that all required information is provided to prevent further delays in processing or a second return for additional information. The signature

requirements for in-system providers will be dependent on the provisions of the agreement and administrative procedures established between the providers and the FI/Contractor. (See Section IV.F.2., of this chapter for additional information.)

**(2)** If the out-of-system provider completes the claim form for the beneficiary, but does not participate, the provider must still sign the form or an acceptable facsimile signature must be used to establish the services were rendered. If the provider does not sign, the FI/Contractor may contact the provider by telephone to verify the delivery of services. Each item must be verified and the calling FI/Contractor employee must document the name of the person contacted, the date and time of the call, and each service shall be initialed by the employee to verify that each was confirmed. The full name of the calling employee should also appear on the claim. A claimant may also attach an itemized bill on the letterhead/billhead of the provider. If any attached itemized bill, causes the FI/Contractor any concern for its validity, it should be verified by call or letter to the provider before payment. If the investigation reveals the possibility of fraud, follow procedures in OPM Part Two, Chapter 7. (Also see Section IV.F.2., of this chapter.)

### d. Certification of Source of Care

Source of care certification is used to help determine the correct payee on the participating UB-82 or UB-92, CHAMPUS Form 500 and the CHAMPUS Form 501. If signed by the provider and the certification is unaltered, issue payment to that provider. If signed with alteration of the certification, issue payment to the beneficiary (parent/legal guardian of minor or incompetent). If unsigned and an itemized billing on the provider's letterhead is not attached, develop for itemized billing.

### e. Provider Certification Requirements

See OPM Part Two, Chapter 2 and the Policy Manual, Chapter 10 for professional providers of care certification requirements.

#### (1) FI/Contractor Requirements

FIs/Contractors are required to establish and maintain appropriate files to document provider qualifications and to maintain a record of those providers whose services are payable under CHAMPUS. When the provider of care is a clinic or other entity categorized as an individual provider of care which includes multiple professional providers such as a psychiatrist or clinical psychologist who employs other psychologists and/or social workers, the identity of the professional provider who actually performed the service must be included on the bill or claim.

**(a)** Providers categorized as clinics or other entities employing other or multiple professional providers must be informed that the names and specialties of provider employees who provide direct patient care must be provided to the FI/Contractor for the provider history files. The names and specialties of the providers must be included on all provider billings or the bills or claims will be returned for development of required information or delayed. FIs/Contractors shall contact any non-certified providers and attempt to develop their eligibility as a CHAMPUS provider in accordance with OPM Part Two, Chapter 2, Provider Certification, and the Policy Manual, Chapter 10.

**(b)** If laboratory tests billed by an out-of-system provider were performed outside the office of the out-of-system provider, the place where the laboratory tests were performed must be provided on attached itemized bills, receipts or

statements, or must be developed, do not acquire this information from the existing file data. The *MCS* contractor shall approve arrangements for laboratory work submitted by in-system physicians. To be covered, the services must have been ordered by an MD or DO and the laboratory must meet the requirements to provide the services as required under the DoD Regulation 6010.8-R, and *TSO* instructions.

### f. Status of Billing

The status of billing (complete or partial) must be present on each hospital claim. If missing, do not acquire from the existing file data. Such information shall be obtained from attached itemized bills, receipts, or statements, or must be developed.

### g. Diagnosis

In order for *MCS* contractors to make benefit determinations regarding the services being claimed and DRG reimbursement determinations, the patient's diagnosis must be indicated by use of standard medical terminology, a diagnostic code, or a description of the presenting symptoms. Diagnostic information need not be questioned if it provides adequate explanation of the patient's condition. For claims containing a narrative diagnosis in combination with a diagnosis code that does not correspond to the narrative, *MCS* contractors shall give precedence to the narrative and revise the numerical code accordingly. Development to resolve the discrepancy is not routinely required. *MCS* contractors shall not develop diagnostic information from existing file data except for attending physicians' claims, in which case the diagnosis may be obtained from the related hospital claim for the same dates of care. *(Also see Section V.C.5.g.(1)(a) below.)* If this information is not present, the claim must be developed by telephone call or controlled return. See the Policy Manual, Chapter 13, Section 6.1B, for development requirements specific to diagnoses on DRG-reimbursed claims.

#### (1) Claims for Certain Ancillary Services - Administrative Tolerances for Diagnosis

**(a)** Provider-submitted claims (participating and non-participating) for inpatient or ambulatory surgery anesthesia, laboratory, and radiology services *or outpatient laboratory and radiology services* shall not be developed or returned for an incomplete, discrepant or missing diagnosis if the billed amount is $200.00 or less and the claims involve only the specified ancillary services. If the billed amount is greater than $200.00, the *MCS* contractor shall develop for diagnosis. *For inpatient or ambulatory surgery services,* the diagnosis from the hospital's, ambulatory surgery center's or attending physician's claim for the same inpatient or ambulatory surgery episode shall be used if on file. *For outpatient services, the diagnosis from the physician's office services shall be used if on file.* Otherwise, code the incomplete, discrepant, or missing diagnosis as 799.9 when the billed amount is $200.00 or less.

**(b)** The administrative tolerance described above is applicable only to provider-submitted claims for the ancillary services cited. This includes claims submitted by an institution when the claim is for those specific ancillary services; and the services were performed in an institution other than the institution in which the beneficiary is receiving inpatient care or ambulatory surgery care.

**(c)** Provider-submitted claims for services other than those cited above, or beneficiary-submitted claims shall be developed for the diagnosis.

**(d)** *MCS* contractors shall conduct an audit review of all ancillary service claims processed with incomplete, discrepant or missing diagnoses and/or beneficiary signature when such claims are in review samples or are "special handling" cases. These cases are claims included in the required one percent internal quality reviews; the claims pulled for *TSO* claim audit (do not delay the audit sample review after it is sent), and those pulled for adjustment or for informal review. These will be audited by comparing against the institutional claim *or related physician claim* for the same period. In the event discrepancies are found which indicate fraud or abuse, refer to the OPM Part Two, Chapter 7, Section III.

### (2) Admitting Diagnosis

*MCS* contractors are not required to develop for an admitting diagnosis for inpatient claims unless the beneficiary resides in a MTF catchment area and the admission information is required to determine if the admission was an emergency qualifying for exemption to the Nonavailability Statement requirement. The primary diagnosis is to be used in place of a missing admitting diagnosis in those instances when an admitting diagnosis is required to meet *TRICARE* data reporting requirements.

### (3) Other Diagnosis Coding Requirements

**(a)** Codes and narratives that describe symptoms and signs, as opposed to specific diagnoses, are acceptable with the assumption that this is the level of certainty documented by the physician. Chapter 16 of ICD-9-CM, Symptoms, Signs, and Ill-defined Conditions (codes 780.0-799.9), contains many, but not all, codes for symptoms. Claims with only this level of diagnoses need not be developed for a more specific diagnosis. However, use of 799.9 (Other unknown and unspecified cause) as a principal treatment diagnosis is limited. (See the ADP Manual, Chapter 3, Edits 2-155-09R, -10R, and -11R.)

**(b)** Inconclusive "diagnoses", such as probable, suspected, questionable, or rule out, do not describe established conditions are insufficient for making benefit determinations on outpatient claims. Outpatient claims containing only these types of "diagnoses" are to be coded with the diagnosis 799.9 and are not to be developed but rather denied for insufficient diagnosis *(except as provided in Section V.C.5.g.(1)(a) above)*. Inconclusive "diagnoses" are not to be accepted as if the patient's condition has been confirmed. If symptoms or signs are also reported on the claim, process the claim based on this more specific information.

**(c)** The ICD-9-CM codes listed in the Supplementary Classification of Factors Influencing Health Status and Contact with Health Services, otherwise known as V codes, deal with circumstances other than disease or injury classifiable to the ICD-9-CM categories 001-999. V codes are acceptable as primary diagnoses on outpatient claims (rarely on inpatient claims) to the extent that they describe the reason for a beneficiary's encountering the health care system. Claims with V codes as the primary diagnoses are to be processed as follows without routine development.

**1** V codes which provide descriptive information of the reason for the encounter based on the single code, e.g., V03.X

(Prophylactic vaccination and inoculation against bacterial diseases), V20.2 (Routine infant or child health check), V22.X (Supervision of normal pregnancy), V23.X (Supervision of high risk pregnancy) V25.2 (Contraceptive management), are acceptable as primary diagnoses. Claims with these codes may be processed according to *TRICARE* benefit policy without additional diagnostic information.

**2** V codes for outpatient visits/encounters involving only ancillary diagnostic or therapeutic services are acceptable as the primary diagnosis to describe the reason for the visit/encounter only if the diagnosis or problem for which the ancillary service is being performed is also provided. For example, a V code for radiologic exam, V72.5, followed by the code for 786.50 (wheezing) or 786.50 (chest pain) is acceptable. If the diagnosis or problem is not submitted with a claim for the V-coded ancillary service *and the diagnosis is not on file for the physician's office services (see Section V.C.5.g.(1)(a) above)*, the claim is to be denied for insufficient diagnosis.

**3** *V codes for preventive services due to a personal history of a medical condition or a family history of a medical condition are acceptable as primary diagnoses when medically appropriate due to the personal or family history condition. Claims with these codes may be processed according to the TRICARE benefit policy without additional diagnostic information. Specifically, the treatment areas are as follows:*

**a** *Diagnostic and Screening Mammography, e.g., V725, V103, V1589 and V163.*

**b** *Pap Smears, e.g., V72.6, 76.2, and V15.89.*

**c** *Screening for Fecal Occult Blood, e.g., V10.00, V10.05 and V10.06.*

**4** Claims with the only diagnoses being V codes which do not fall into one of the above of categories, e.g., codes indicating personal or family histories of conditions, are to be denied for insufficient diagnosis. This includes those V codes corresponding to the V codes for "Conditions not Attributable to a Mental Disorder" in the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association.

### h. Itemization

The date and place of each service, as well as a description (or a procedure code from an identified system acceptable to the *MCS* contractor) and charge for each service, must be present on the claim form or on attached bills, receipts, or statements. The *MCS* contractor shall not develop this information from existing file data. If this information is questionable or incomplete, the claim must be developed by telephone call or controlled return. If this information is missing, i.e., no itemization is submitted with a claim, the claim is to be returned uncontrolled with a request that detailed itemization of the services be provided according to the requirements in this section. Claims supported only by "balance due," or summary, billings or explanations of benefits from primary coverage plans, regardless of the level of detail in the latter, do not meet itemization requirements and are to be returned uncontrolled for acceptable itemization.

### (1) Inpatient Institutional Services

The institutional provider must identify each kind of service provided, e.g., operating room, laboratory services, radiology services, etc., and indicate the number of days, the accommodation rate per day (if needed for reimbursement purposes), and the total charge for each kind of service. If incomplete or discrepant on the claim, the information shall be obtained from attached itemized bills, receipts, or statements, or by telephone or through controlled written development. Except for accommodation rates, do not acquire this information from existing file data. If itemization is totally lacking, the FI/Contractor shall return the claim uncontrolled with specific instructions that itemization must be provided before the claim can be processed.

***NOTE:***

*The kind of service provided will be identified on the Form UB-82 or UB-92 by the 3-digit (may be expanded to 4-digit in the future for UB-92) revenue code.*

### (2) Outpatient Institutional Services

**(a)** The out-of-system institutional provider must identify each kind of service provided; e.g., emergency room, laboratory services, radiology services, etc., and provide a total charge for each kind of service. The appropriate "Not Otherwise Classified Code" (NOC) shall be used. The in-system providers shall comply with the agreements with the FI/Contractor. All data required for accurate completion of the health care service record must be provided/obtained whether the provider is in-system or out-of-system.

**(b)** Bills which combine the same types of services, with inclusive dates of service, do not need to be developed for individual dates of service. However, charges which appear to be excessive for the diagnosis or for the services provided should be developed to determine if there is a valid medical reason for an unusual level of services and charges. See OPM Part Two, Chapter 4, for reimbursement requirements on claims containing inclusive dates and combined charges. (See Section VI.E., for related instructions.)

### (3) Individual Provider Services

#### (a) Itemization Requirements

Claims for individual providers (including claims for ambulatory surgery) usually require materially more detailed itemization than institutional claims. The claim must show the following detail:

**1** Identification of the provider of care;

**2** Dates of services;

**3** Place of service, if not evident from the service description or code, e.g., office, home, hospital, skilled nursing facility, etc.;

**4** Charge for each service;

**5** Description of each service and/or a clearly identifiable/acceptable procedure code; and

6 The number/frequency of each service.

### (b) CHAMPUS/CHAMPVA Claim Form DD 2520

*The CHAMPUS/CHAMPVA Claim Form 2520 allows a provider to certify the services or supplies rendered by listing them and signing item 33, whether an in-system provider or an out-of-system provider, participating or not. A provider-completed form is adequate documentation. If the Form DD 2520 is not signed (stamped) by the out-of-system provider, a separate itemized bill, receipt, or statement of services or supplies, prepared on the provider's billhead must be attached before the claim may be processed. If itemization is incomplete, discrepant, do not acquire this information from the existing file data, but develop through written request or a documented call, if appropriate. See Section V.B. of this chapter regarding missing itemization. An unsigned provider-completed claim is to be returned uncontrolled to the claimant for the provider's signature or a separate itemized bill on the provider's billhead (nonparticipating claims only). In-system providers will comply with required provisions of the Contractor's agreement and established Contractor/provider administrative procedures.*

*Note: After December 31,1995, the DD Form 2520 will no longer be acceptable for CHAMPUS claims filing except for services in foreign countries.*

### (c) Exceptions to Itemization Development Requirements for Individual Provider Claims

The tolerances below may be used at the FI/ Contractor's option. OCHAMPUS waives its usual requirement for detailed procedure data on health care service records.

1 When the individual provider of care bills for one or more laboratory services under only the general description of laboratory tests or services and the total charge for these services is $50 or less, the line item need not be developed for specific description or procedure. If the diagnosis or description of illness supports the reasonableness of one or more laboratory services being performed in connection with other CHAMPUS covered services, the charge will be deemed allowable and adjudicated accordingly. If the diagnosis or description of illness does not support the inclusion of one or more CHAMPUS covered laboratory services, the charges for these services must be denied or developed.

2 When the individual provider of care bills for services in radiology under only the general description of radiology or x-ray and the charge for these services is $75 or less, the line item need not be developed for specific description or procedure. If the diagnosis or description of illness does not support the inclusion of one or more CHAMPUS covered services in radiology, the charges for these services must be denied or developed.

### (4) Prescription Drugs and Medicine (and Insulin)

MCS contractors shall accept pharmacy receipts (legible photocopies of pharmacy receipts are also acceptable) or prescription listings on pharmacy letterhead, which contain all the information required below.

***NOTE:***

*Outpatient institutional services do not require itemization unless there is reason to question the claim and/or charges.*

#### (a) Minimum Requirements

The following information is required:

1. The name of the patient.
2. The name, strength, and quantity of each drug.
3. Prescription number of each drug, except insulin.
4. The cost of each drug.
5. The date prescription was filled.
6. The name of the prescribing physician.
7. The name of the pharmacy where the drug was purchased.

***NOTE:***

*While not required for HCSRs, many electronic media claims pharmacy systems require the reporting of the Drug Enforcement Administration (DEA) number for controlled substances. To fill controlled substance prescriptions, all prescribers are required to provide this number. For all prescriptions written by MTF providers that are to be honored by civilian pharmacies, the MTF providers will place on the prescription, in addition to the above requirements, the name of the MTF, and the MTF's DEA number followed by a hyphen and a sub-identifying number that is prescriber specific such as the last four digits of the provider's Social Security Number. MCS contractors are only required to inform their network pharmacies of the requirements for MTF provider controlled substance prescriptions.*

***NOTE:***

*Because prescriptions are paid as billed, you may use "Your Pharmacy" on the CEOB on non-assigned prescription claims. It is not necessary to develop for the actual name and address of the pharmacy. If the name of the provider is known, the MCS contractor is required to verify that the provider is not sanctioned, excluded or terminated from the TRICARE program prior to adjudication of the claim submitted by either the provider or the beneficiary. Claims for medical supplies or DME purchases from pharmacies are not*

*included in this category. If the beneficiary has a "prepaid prescription plan" in which the beneficiary pays only a "flat-fee" no matter what the actual cost of the drug, the FI/Contractor shall costshare the fee and not develop for the actual cost of the drug, since the beneficiary is only liable for the "fee." Refer to Policy Manual, Chapter 13, Section 13.3.*

### (b) Drug Claim Tolerances

The FI/Contractor should establish drug tolerances for controlled and uncontrolled drugs to guard against abuse. The guidelines in use at OCHAMPUS are available upon request.

### (c) Claims for Drugs Dispensed Under a Manufacturer's Charge Card Program

In some instances, only a single manufacturer may produce a certain drug (e.g., Berlex Labs is the sole producer of Betaseron for multiple sclerosis) and may establish a charge card program for the distribution of the drug. In such situations, the patient establishes an arrangement with the manufacturer to pick up the drug at a local pharmacy, but agrees to make payment directly to the manufacturer. The local pharmacy does not collect any money or charge the beneficiary for the drug, since the beneficiary has already paid the manufacturer.

**1** In instances such as those described above, the manufacturer will send an invoice-like document (e.g., a "Credit Transaction Record") to the patient, showing the amount the patient has been charged for the drug. However, these documents may contain a disclaimer stating: "This is not an Invoice for Payment" or similar language, along with a "fine-print" explanation of the charge card program. At the same time, the patient's receipt from the dispensing pharmacy will show charges of "zero," leaving the patient without a true bill from the manufacturer or an itemized receipt from the dispensing pharmacy.

**2** Where it can be established that a beneficiary has obtained drugs under a manufacturer's charge card program, the claim may be processed for payment when it is accompanied by BOTH:

**a** The manufacturer's Credit Transaction Record which reflects the actual charges to the patient; and

**b** A record/receipt from the dispensing pharmacy showing the drug was actually dispensed to the patient.

**3** Under the circumstances described above the patient is responsible for payment to the manufacturer; therefore, claims shall be reported as consolidated drug claims, with the provider shown as "Your Pharmacy".

### (5) Ambulatory Surgical Centers

Ambulatory surgery centers (either freestanding or hospital-based) may bill both facility charges and professional charges on a HCFA 1500 claim fo. ı, and the facility charges are reimbursed based on the procedures performed (by CPT-4 or HCPCs code). Facility charges and professional charges cannot be filed on the same claim, and all claims for ambulatory surgery services billed on a HCFA 1500 must

indicate whether the claim is for facility charges or professional charges and the procedure(s) performed. If this information is not provided, the FI/Contractor is required to develop the claim for it. Only ambulatory surgery facility charges can be billed on the UB-92, so the FI/Contractor need not develop these claims for information on whether the claim is for facility or professional charges, but they may still need to develop such claims for the procedure(s) performed.

### i. Total Charges Billed, Amount Paid by Beneficiary (if applicable), and Amount Paid by Other Insurance (if applicable)

If needed information is missing, obtain it from itemized bills, receipts or statements and other insurance explanation of benefits statements, otherwise, develop the claim as required by OPM Part Two, Chapter 3.

## 6. Attachments to a Claim

When appropriate, Nonavailability Statements, other health insurance explanations of benefit, medical statements or operative reports may be required as attachments to properly document a claim. The NAS may be maintained "on file" at the inpatient facility for electronic media (EMC), UB-92 and UBF-1-81 claims. Automated NAS data obtained from DEERS must be stored in the FI/Contractor's automated claims history file in the same manner as the DEERS eligibility responses. For INASs issued on and after April 1, 1991, the INAS authorization within the appropriate effective date parameters must reside on DEERS or the FI/Contractor shall deny the claim. If the INAS issue date is unknown or prior to April 1, 1991, refer to Section IV.G.1.c., for requirements. The FI/Contractor must screen to ensure all necessary attachments are included. Refer to Section IV.H.5.b.(2), Section IV.J.3.a., OPM Part Two, Chapter 3, Section II.B.2. and OPM Part Two, Chapter 12, Section I.C.

### a. Inpatient Nonavailability Statement

#### (1) For INASs issued prior to April 1, 1991

If the FI/Contractor receives a claim which appears to require a Nonavailability Statement, (DD Form 1251), and a 1251 is not attached and an INAS does not appear on the automated DEERS system, the FI/Contractor shall make a reasonable effort to cross-reference to any other claims in process or which have been processed, which cover the same inpatient stay or obtain the information from the DEERS record. In establishing a cross-reference, the FI/Contractor may review the hard copy INAS from the previously processed claim or search the history files for a positive indicator; e.g., an INAS was determined to be available with a related claim. If there are no claims to cross-reference for the Form 1251 and the claim does not appear to qualify under other health insurance exemption provisions or the emergency admission provisions, then the FI/Contractor must develop for the Form 1251 following standard development procedures. (See Section IV.G.1.c., for development requirements when the INAS issuance date is unknown. Also see Section IV.G.1., and the Policy Manual, Chapter 11, Section 2.1.)

#### (2) For INASs issued on and after April 1, 1991

The FI/Contractor shall deny claims if the INAS authorization within the effective date parameters does not reside on DEERS. The DD Form 1251 is no longer an acceptable INAS authorization. If the INAS issuance date is unknown, the FI/Contractor shall develop for the INAS; see Section IV.G.1.c., for the requirements.

### b. Screening Requirements

The CHAMPUS claim form(s) certifying an emergency admission is reviewed in the same manner as all other claims. If a Nonavailability Statement is required for a patient's area of residence, but not submitted for inpatient benefits being claimed or noted as being "on file," the FI/Contractor shall screen the claim and any accompanying medical documentation to determine if the care meets the definition of medical emergency in Policy Manual, Chapter 1, Section 7.1 and Chapter 13, Section 15.1or determine and cross reference if such information was submitted on another claim for the same admission. If the care meets the definition of medical emergency, the claim shall be processed without further review. If a determination cannot be made, the following screening and review requirements apply. These apply to all emergency admissions; i.e., medical, surgical, psychiatric or maternity unless otherwise specified. Generally, the attending physician determines medical emergency, subject to review and verification by the FI/Contractor.

#### (1) Claim Review

The information provided on the claim form(s) must contain detailed and explicit information concerning the medical circumstances resulting in the emergency admission. This information should be provided regardless of the admitting diagnosis or type of care. FIs/Contractors shall not automatically deny the claim because a Nonavailability Statement is not attached or noted as being "on file." Nor should the FI/Contractor pay a claim based on the appearance of an emergency, e.g., emergency room charges are being claimed. Additional information must be obtained, as specified below, to establish the case as an emergency. Development is not required for the "closest hospital" requirement (see the Policy Manual, Chapter 1, Section 7.1, Policy Considerations) unless the FI/Contractor has reason to question the location of the admitting hospital. If the case involves an emergency maternity admission, the physician must also certify that he or she had not provided any prenatal care to the patient during her pregnancy, prior to the date of the admission.

#### (2) Additional Documentation

If a determination cannot be made from the information submitted with the claim that the admission qualifies as a medical emergency, the FI/Contractor will obtain a copy of the admitting history, physical, and doctor's initial orders. The case will then be referred for medical review to determine whether the case falls within the Program's definition of Medical Emergency. Medical review may determine that additional information is required, and request the complete hospital record and/or contact the attending physician.

### c. Fraudulent Information

Falsifying information; e.g., providing an incorrect residence address, creating information concerning a medical emergency, etc., to circumvent the requirements to use a Uniformed Services medical facility, is considered fraud. FIs/Contractors will handle in accordance with requirements in OPM Part Two, Chapter 7.

### d. Appeals

Beneficiaries have the right to appeal any adverse determination of medical emergency or its termination.

### e. All Review Guidelines Apply

Notwithstanding the special requirements related to a medical emergency, all standard claims review guidelines apply to such cases, e.g., eligibility, covered services, authorized provider, etc.

### f. Explanation of Other Health Benefits

Other health insurance data must be obtained whether by claim return, written request, or from the insurance carrier by phone. The FI/Contractor shall follow the procedures in OPM Part Two, Chapter 3.

### g. Medical Statements

Medical statements and operative reports are not usually required on routine claims. If necessary to process a claim to payment, medical statements may be required by the FI/Contractor's medical staff. Medical statements/operative reports may be clarified, by phone, with the provider, if not clear.

### h. Authorizations

Clarification of authorizations shall be made with the FI/Contractor benefit authorization unit, if necessary. If the data on the claim clearly does not match the authorization, and if the discrepancy cannot be resolved by the contact with the authorizing unit, deny the claim with the message that the "claim does not match authorization."

## D. Eligibility Verifications

### 1. CHAMPUS Claim Information Questionable - Fraud Not Suspected

**a.** The FI/Contractor shall develop claims when there is reason to question the patient's eligibility based on the claim form information provided but fraud is not suspected.

***EXAMPLES:***

*"Medicare" is indicated on the claim as the other health insurance but DEERS reports the patient as CHAMPUS eligible (especially true for individuals under the age of 65), and*

*Correspondence or claims history indicates the patient is divorced from the sponsor or a dependent child has married, or*

*When other correspondence is received which raises some question about the eligibility.*

**b.** Normal development procedures in the above examples would involve obtaining copies of the patient's Medicare card, divorce decree or marriage certificate; however, a statement from the patient certifying the loss of CHAMPUS eligibility is sufficient. If the loss of CHAMPUS eligibility is documented and even though DEERS shows the beneficiary to be eligible, the FI/Contractor shall deny the claim according to the instructions in the ADP Manual, Chapter 9, Section IV.A.2.e. Supporting documentation shall be submitted to DEERS according to the ADP Manual, Chapter 9, Addendum C.

### 2. CHAMPUS Claim Information Questionable - Fraud Suspected

When the evidence indicates fraud may be involved in the attempt to establish eligibility, refer to OPM Part Two, Chapter 7 instructions.

### 3. Dispute on Question of Eligibility

When the beneficiary disputes the FI/Contractor's decision to deny a claim based on the information developed under the requirements of Section V.D.1., reconfirm the eligibility decision by querying DEERS.

#### a. DEERS Eligible

If DEERS still indicates CHAMPUS eligible, initiate a CHAMPUS Form 88R with supporting evidence attached to the DEERS Support Office (DSO), 2511 Garden Road, Suite 260A, Monterey, CA 93940, for CHAMPUS claims only. The FI/Contractor shall inform the beneficiary of this action and that there will be a delay in resolving his or her complaint. If the DEERS' response to the CHAMPUS Form 88R confirms eligibility, the FI/Contractor shall reprocess the denied claim as a new claim with a new claim number.

#### b. DEERS Ineligible

If the DEERS query indicates that the patient is not eligible, the initial claim denial must be upheld and the beneficiary informed to contact either the nearest military ID card section or DSO to reestablish eligibility.

## E. Verification of Current Address

### 1. Claim Development Requirement

If there is reason to question the beneficiary or sponsor address on the claim and the current address is needed for development or payment purposes, review the existing file data or make telephone contact with the beneficiary or provider to verify or obtain the information. FIs/Contractors who have on-line access to DEERS screens providing sponsor or beneficiary's addresses may use DEERS. If these attempts to obtain the correct address are unsuccessful and the claim is nonparticipating, deny the claim. If the provider is participating, the FI/Contractor shall follow the requirements in Section IV.F.1.f.(5)(a) of this chapter. Attempts to verify or obtain the current address must be filed with the claim.